



CERTIFICATE OF INSURANCE COVERAGE
NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
FINGER LAKES INDEPENDENCE CENTER, INC.
215 FIFTH STREET
ITHACA NY 14850
1b. Business Telephone Number of Insured
607-272-2433
1c. Federal Employer Identification Number of Insured or Social Security Number
16 1330345
2. Name and Address of Entity Requesting Proof of Coverage
NY STATE EDUCATION DEPT
89 WASHINGTON AVE
ALBANY NY 12234
3a. Name of Insurance Carrier
The Guardian Life Insurance Company of America
3b. Policy Number of Entity Listed in Box 1a
00926325-0000
3c. Policy Effective Period
07/01/2024 to 07/01/2025

4. Policy provides the following benefits:
A. Both disability and Paid Family Leave benefits.
B. Disability benefits only.
C. Paid Family Leave benefits only.
5. Policy covers:
A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
B. Only the following class or classes of employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS disability and/or Paid Family Leave benefits insurance coverage as described above.

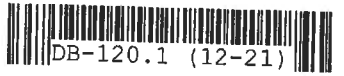
Date Signed 08/21/2024 By [Signature]
(Signature of insurance carrier's authorized representative or NYS licensed insurance agent of that insurance carrier)
Telephone Number 1-888-278-4542 Name and Title Michael Prestileo, Head of Group Benefits Strategy, Product & Underwriting

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be emailed to PAU@wcb.ny.gov or it can be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have been checked)

State of New York
Workers' Compensation Board
According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law(Article 9 of the Workers' Compensation Law) with respect to all of their employees.
Date Signed \_\_\_\_\_ By \_\_\_\_\_
(Signature of Authorized NYS Workers' Compensation Board Employee)
Telephone Number \_\_\_\_\_ Name and Title \_\_\_\_\_

Please Note: Only insurance carriers licensed to write NYS disability and Paid Family Leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.



## CERTIFICATE OF WORKERS' COMPENSATION INSURANCE (RENEWED)

\*\*\*\*\* 161330345  
FINGER LAKES INDEPENDENCE  
CENTER INC  
215 FIFTH ST  
ITHACA NY 14850



SCAN TO VALIDATE  
AND SUBSCRIBE

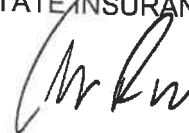
<b>POLICYHOLDER</b> FINGER LAKES INDEPENDENCE CENTER INC 215 FIFTH ST ITHACA NY 14850		<b>CERTIFICATE HOLDER</b> NY STATE EDUCATION DEPT 89 WASHINGTON AVE ALBANY NY 12234	
<b>POLICY NUMBER</b> E1326 591-3	<b>CERTIFICATE NUMBER</b> 954653	<b>POLICY PERIOD</b> 07/01/2024 TO 07/01/2025	<b>DATE</b> 7/9/2024

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1326 591-3, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

**IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.**

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND



DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 692381199